13. Community-Driven Projects

Project 1: Care Transitions

a. CI: Care Transition Teams

b. Project Selection Rationale and Expected Outcomes

Region 7 selected Care Transition Teams as a community-driven project in order to increase needed support that is critical when individuals with serious mental illness transition from the hospital setting back into the community. Over ten percent of inpatient readmissions in Region 7 are individuals with behavioral health factors, as compared to four percent with no behavioral health indicator. Thirty-two percent of Region 7's Medicaid population has a behavioral health indicator, while the same population makes up over 65% of total inpatient admissions. Nationally, between 40 and 50 percent of patients with a history of repeated hospitalizations are readmitted within 12 months.[1] Readmissions are costly, disrupt individuals and families, and often leave providers and patients feeling frustrated. Although severity of mental illness may result in readmissions, in some cases readmissions may be more related to access to community resources and support. An important factor in decreasing the likelihood of readmissions is an effective discharge plan and delivery of sufficient support to transition mental health services from an inpatient to an outpatient setting. Additionally, preventing readmissions includes providing alternatives to support patients, including access to community treatment services and supported housing if necessary.

Emergency department visits are generally not designed to focus on care transitions and coordinated care, or to promote prevention and compliance with care plans. Hospitals face increasing capacity and resource constraints related to the use of emergency departments, and it is an expensive model for care. Care transition teams will assist with reduction of the burden on hospitals that experience high rates of emergency department use by individuals with behavioral health indicators. Despite accounting for only 32% of the total IDN beneficiary population, members with a behavioral health indictor accounted for 52% of the emergency department visits in 2015. Forty-five of the Region 7 IDN members with a behavioral health condition had at least one emergency department visit in 2015, compared with 27% of members who did not have evidence of a behavioral health condition. Frequent emergency department utilizers (those who visited the emergency department 4 or more times in any given year), made up only 4% of the total population, yet accounted for thirty-five percent of all emergency department visits in 2015. Among frequent emergency department utilizers, 67% of Region 7 IDN members had evidence of a behavioral health condition. Among the total IDN member population, only 32% have a behavioral health indicator. Overall, frequent emergency department utilizers with a behavioral health condition accounted for 24.32 % of the total emergency department visits by IDN members, despite making up only 2.4 % of the total IDN member population. Patients with evidence of a behavioral health condition accounted for 45% of all potentially avoidable emergency department visits[2], despite accounting for only 32% of the total member population.

Region 7 IDN partners selected Care Transition Teams as a community-driven project after consideration of the feasibility of implementing the Critical Time Intervention model. IDN participants agreed that the model will increase capacity and enhance care transition planning currently in place. Participants identified several areas that will be addressed through this project, including such things as:

- Recidivism that occurs and significantly burdens local capacity;

[1] http://www.effectivehealthcare.ahrq.gov/

[2] State definition: The list of selected potentially treatable diagnoses were identified as common diagnoses having a higher likelihood of being non-urgent or treatable in the primary care setting rather than the hospital emergency department. The list is not exhaustive and is not intended to represent all potentially avoidable diagnoses nor are all visits avoidable. The group of diagnoses together are used by the Department as an indicator of potential overutilization of the emergency department.

- Education for patients and families about the unique needs of transitioning back into the community;
- Effective discharge planning that includes effective feedback and follow-up

Additionally, patients with serious mental illness, particularly those with other chronic illnesses, may be vulnerable to unplanned hospital readmissions. A significant population in Region 7 have both a physical health condition and a behavioral health indicator. For example, 32% of adults between the ages of 50 and 64 have a cardiovascular condition as well as a behavioral health indicator; 15% of adults 50-64 have both diabetes and a behavioral health indicator; and nearly 34% of adults 50-64 have both a respiratory condition and a behavioral health indicator.

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. [3] CTI is a time-limited phased approach that is highly focused during the transition period. Region 7 will implement CTI or a similar intervention to ensure effective care transitions. Within three years, the region will reduce by 20% the number of preventable hospital readmissions that occur within thirty days of discharge. Region 7 IDN partners prioritized three long-term outcomes for this project focusing on the individual, the community, and the systems:

1. **Individual:** Individuals will reach or sustain recovery for the long term
2. **Community:** Communities will establish capacity for connecting individuals with consistent and available care and resources to empower patients
3. **Systems:** Implementation of efficient, effective, integrated, and cost-effective systems that achieve patient recovery

Short-term outcomes in each priority area have also been identified:

Individual

a. Individuals will be successfully identified and assisted through the CTI model in at least six IDN partner organizations by December 2017
b. Clients are integrated into the community through development of independent living skills and building support networks, beginning June – December 2017

Community

c. Effective resources support networks in place for clients by December 2017
d. Community services and supports will be mobilized and coordinated by June 2017
e. CTI model is successfully implemented in six IDN partner organizations by December 2017

Systems

f. Regional sustained CTI training program will be in place for organizations inexperienced in a three-phased model of care transitions by June 2017
g. Secure messaging systems between participating organizations will be in place by June 2017

c. Participating Organizations: Selection Criteria

Organizations choosing to participate in this project will submit a proposal in response to the sub-recipient request for funds previously discussed. Organization's proposals will be reviewed to ensure they meet the criteria below for effective implementation of the project. Organizations will either propose as individual entities or in conjunction with community partners to carry-out the Critical Time Intervention model (or something similar), and demonstrate

[3] www.criticaltime.org

capacity to implement and report progress toward improved outcomes. Participating organizations will include hospitals, primary care providers, behavioral health providers, and community based social service organizations. Organizations that participate in the Care Transitions Community-Driven Project will be providers who are advocates for patients and who are trained to empower patients and their families to actively participate in the care transition process. Organizations will be asked to exhibit thoughtful collaboration among hospitals, community-based organizations, long-term and post-acute care providers, patient caregivers, and patients and their families. They will be required to have demonstrated experience and ability to work with individuals with behavioral health needs. Organizations that participate in Care Transition Teams will have effective outreach and engagement by staff working in the community rather than just the office. Organizations will be asked to demonstrate how staff will be engaged and trained in the Critical Time Intervention model as well as methods that will be used to achieve improvement in the effectiveness of the transitions of patients between care organizations. Participating organizations will be patient/client centered.

Organizations participating in this project will demonstrate capacity to design, and/or enhance a clinical services infrastructure that will support:

- Standardized protocols for Care Transition Team models
- CTI team members
- Participation in training planning and curricula
- Agreements with collaborating organizations
- Evaluation, including metrics used to measure program impact
- Mechanisms to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

Participating organizations will have care teams that are encouraged to be informed about collaboration across the continuum of care. Teams will be expected to be knowledgeable about available services and resources, such as mental health and/or chemical health support groups, social services, financial assistance for medication, transportation assistance, nutritional support, and emergency housing assistance. Effective Care Transition Teams will be expected to include:

- Patient/family engagement and activation in their care
- Early identification of patients/clients at risk
- Medication management
- Comprehensive transition planning
- Care transition support
- Multi-disciplinary collaboration
- Effective transfer of information to collaborating partners

e. Monitoring Plan

Organizations implementing Critical Time Intervention (CTI) to facilitate smooth transitions of care for adults with serious mental illness from the hospital setting into the community will be required to monitor and report to the IDN Lead agency on a regular basis. All organizations will be required to have staff complete the CTI training, and identify a mental health professional that will provide supervision. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement the project. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring activities will include: 1) tracking activities to monitor implementation and participation in activities; 2) targeted qualitative methods (eg. semi-structured interviews) to

understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively; 3) review of available outcomes data related to the region to understand progress in population health. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data.

The measurement plan for Region 7 provides information about collection data for each primary objective. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard.

Measurement plan for Region 7

	What	Where	How	When	Who
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Provide adults with serious mental illness with effective transitions of care	50% of identified patients complete CTI	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	50% of identified patients integrated into community services	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	75% of participating individuals and families provide feedback, eg..satisfaction	Program Survey	On-line survey program	Annually	Program Manager
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Provide IDN partner organizations with design and development of infrastructure to implement CTI model	Agreements in place between collaborating organizations	Program Documents	Signed agreements	Quarterly	Program Manager
	75% of staff in identified organizations trained in CTI	Program Documents	Completed training of care managers Supervisors identified	Quarterly	Program Manager Northern New Hampshire AHEC
	Secured messaging in place for	Patient care plan template	Participating organizations provide	Quarterly	Program Manager IT Manager

	participating organizations		feedback and revisions for efficient template		
	CTI model is implemented with fidelity Participating	Program Documents	IDN Tracking Tool	Quarterly	Program Manager

Potential dashboard measures of this project are illustrated below:

Objective	Measures	Target	Frequency	Findings	Trending
Goal 1: Individuals will reach or sustain recovery for the long term					
	Targeted individuals assisted through CTI model	50%	Monthly	# patients/clients	
	Clients integrated into community	50%	Quarterly	#services provided #IDN partner connections	
Goal 2: Communities will establish capacity for connecting individuals with consistent and available care and resources to empower patients					
	CTI model implemented in partner organizations	20	Monthly	#staff recruited	
	Resource networks in place	75%	Quarterly	#agreements with collaborative agencies	
Goal 3: Implementation of efficient, effective, integrated, and cost-effective systems that achieve patient recovery					
	Sustained CTI training program	100%	Quarterly	#staff trained	

f. Challenges and Proposed Solutions

Challenges to implementing this project and key barriers to successful implementation of outcome measures were identified by IDN stakeholders.

1. Communication

   Communication was identified as the number one challenge to effective implementation of care transitions. Integration of services will only be achieved if effective communication between service providers, community members, clients, and families is improved. Effective communication is part of the core skills required by all health and social service practitioners to ensure that they are effective at meeting the needs of the people who use the services. Practitioners need to be aware of and implement the use of effective communication tools. When it works well, communication helps establish trusting relationships, ensures information is passed and understood, and enriches the lives of people being served. If communication is not effective, it can lead to misunderstandings, resentments, and frustrations for the patients/clients, families, and health care staff.

2. Accessibility

Accessing services may be challenging even when there is a care transitions model in place. The primary challenges include: transportation, workforce, and resources.

Transportation is often challenging for individuals in our rural communities. The low population density and geographical distance in the region can be isolating for many rural residents and impact their ability to access mental health services. Region 7 residents have to travel by private vehicles, which often poses problems for both elderly and low-income populations. The geographic distance often required to access services can be significant. At times secondary roads in the region are closed for days because of extreme weather conditions in northern New Hampshire. Public transportation and taxi service are unavailable in the region.

Workforce capacity was identified by IDN stakeholders as a significant barrier to effective implementation of care transition teams. Although this barrier will be addressed through other project initiatives, in order for there to be a successful program in place it is important to acknowledge this challenge. Increasing workforce capacity in the region will enhance the ability to have trained staff to implement the CTI initiative.

Accessing resources such as housing and social supports is challenging for many individuals trying to navigate a complex system of services. For some, affordable supportive housing is just not available. The region suffers from a lack of hospital beds, transitional housing, crisis apartments, and supported employment. Social supports may not be in place, which, as noted earlier, is imperative for effective care. It may be challenging for CTI providers to refer patients to services due to personal situations that do not fit into "prescribed" systems. While taking local and regional resources into account, providers must be patient-centered, or individualized in their referrals as transitions are put in place.

Strategies for improved access to transition services may include:

- In addition to the CTI clinical staff that is trained, hiring outreach workers (for example, Community Health Workers), who are from the specific communities they serve, may be an effective addition to the care transition team. An effective way to connect with patients is to recruit community residents to be outreach workers who may be Community Health Workers (CHWs). CHWs may also be an on-going connection to the community for patients once CTI is terminated. CHWs can play a role in helping to mobilize and coordinate housing, services and supports in the community.
- Development of a universal patient care plan template that would be used by all outpatient providers and patients. If a common care plan is used throughout the system communication will be increased and patients will not have to be faced with "re-telling" their story each time they access new services and resources.
- Utilization of a patient health record that is maintained by the patient. This would be an effective way to empower patients to self-manage their health care. It would also be a tool that would keep family or social support members informed.
- A well-maintained web site managed by the IDN Lead Agency with information for patients/clients, health care and social service providers, and community members.
- Development of processes and protocols throughout referral systems that are consistent and easy to navigate.